IMR-6

Major Findings Review

EXHIBIT A

APD's "Reactive Response"

- Each IMR viewed by APD as an "event to be managed"
- Should be viewed as highly detailed and specific identification of issues to be analyzed, prioritized, and solved
- Requires application of problem-solving processes

EXHIBIT A

Current Strategies

- Box-checking
- Disjointed (no integration across supervisory, mid-management, command, executive levels)
- Each IMR is viewed as an independent event
- Poor integration of events reported in last IMR into APD's "problem-solving" processes for the next cycle
- Little, if any, integration of CASA requirements across organizational "silos"

EXHIBIT A

Systemic Failures

- Follow-up activities related to past feedback from monitor has been limited and rudimentary
- Complete Entropy of Use of Force Systems
  - Failed at Supervisory levels
  - Failed at mid-management levels
  - Failed at command levels
  - Failed at Executive levels

EXHIBIT A

"Handcuffed Prisoner"

- No meaningful review at any oversight level: sgt, lt, cmdr, DC, FRB
- 44 individual errors beginning with initial supervision and following through to FRB review, which ended in dysfunction, including but not limited to:

EXHIBIT A

Handcuffed Prisoner cont'd

- Failure to report a serious use of force (injury) & address complaints of pain by suspect
- Misleading Supervisor statements & report inconsistent with the facts
- Delay in notifying CIRT rationalized by Supervisor (potential false reporting by Supervisory personnel)
- Failure to accept complaint of injury

EXHIBIT A

CIRT Follow-Up re "Handcuffed Prisoner"

- Failure to initiate a timely IA misconduct investigation, despite obvious and serious policy violations
- Failure to investigate a serious use of force for 8 months
- CIRT detective reviewed an obviously out-of-policy SUoF
- CIRT detective failed to identify a SUoF
- CIRT detective failed to identify collateral allegations

EXHIBIT A

CIRT Follow-Up (cont'd)

- Failure to obtain a prosecution declination
- Along with Chain of Command, failure to ID obvious candor issues on the part of the officer (OBRD did not match arrest report, etc.)
- Failure to immediately refer allegations to IA

EXHIBIT A

Supervision and Investigative Follow-Up

- Command failure to properly supervise the investigation and hold CIRT personnel for failing to investigate the event
- **IA** allowed an unreported SUoF to go uninvestigated for more than 8 months
- **IA** failed to initiate an "internal" when made aware of serious policy violations
  - Deferred case to FRB who processed it more than a year after the event!

EXHIBIT A

FRB Failures

- Failed to review full investigative record
- FRB resistance to assessing all elements of policy violations
- FRB members averred they had reviewed video when they later admitted they had not

EXHIBIT A

Tepid Responses to Failure of FRB

- Counseling memos to IA and CIRT following FRB meeting
  - Appropriate response would have been an internal assessment (audit) to ensure APD had identified all lapses
    - Production of report identifying lapses
    - Production of report identifying causes
    - Production of report identifying remedies
    - Follow-up on implementation of recommendations
  - ***APD continues to react tepidly to CASA violations***
  - Observed response was ineffectual and timid

EXHIBIT A

Unilateral IAB Suspension of Policy

- March 10, 2017 Memo from CIRT supervisor (Lt.) suspending parts of APD policy on CIRT investigations
  - Not provided to monitor (though it affected policy approved by monitor)
  - Discovered through painstaking MT review
- Unilateral suspension of approved policy was addressed to CIRT in March 2017 by lieutenant
- Followed up with written order rescinding the suspension in July, 2017
- Event shows ***five months*** of "practice" contravening APD policy & the CASA.

EXHIBIT A

Continued Failure to Remedy Improper Uses of Force

- Continued failure to report or remedy serious lapses and intentional violation of policy, training, supervisory and management responsibilities related to Use of Force via field and internal investigation and review
- "Under Use of Force" continues to be an issue despite identification of this as a critical issue to be addressed by APD

EXHIBIT A

Training Gaps and Course Outline Documentation

- As of IMR-6, still no movement to develop a comprehensive Training Plan, despite frequent monitor recommendations
- Continued "gaps" in training despite monitor's multiple issuance of Gap Analyses

EXHIBIT A

Training Gaps, cont'd

- Multiple attempts by APD to address training gaps despite warnings early on that existing "plan" was deficient
  - Incoherent
  - Sporadic
  - Not responsive to findings and recommendations noted in IMRs 1-5
  - Deliberate resistance to established practice continues through IMR-5

Training Gaps (cont'd)

- Retrain the OBRD policy from the special order that was rescinded in July, 2017
- Reduced number of OBRD reviews required by policy without consultation with the monitor or Parties

EIRS Implementation

- Subterfuge re EIRS "triggers" revision
  - Reducing time periods by 50%
  - Keeping trigger levels constant
  - Effectively ***doubles*** number of violations before an intervention is required

EXHIBIT A

EIRS Implementation (cont'd)

- Change was not noted reliably in documentation forwarded to monitor
- Such practice has created an inability to move policy review to other members of the monitoring team and moves that task to monitor
- Degrades ability of supervisory and command personnel to identify patterns, training issues, etc.

EXHIBIT A

ECW Safeguards

- After six reporting periods, APD still has provided no published or implemented audit process for ECW usage
- Audit "plan" was provided to monitor in August 2016 but no "movement" as of July 2017

EXHIBIT A

Data Acquisition Issues

- Despite multiple requests for actual data, APD continued to send data as "links"
  - Cumbersome
  - Often inoperable
  - Expire which eliminates APD's earlier problem re "losing" OBRD data only to have MT provide existing copy saved to their DBs
- Data provided often are data APD wants to send, not data requested by monitor
  - e.g. Ask for "cases"//Get "ledgers"

EXHIBIT A

Integration of External IAB Training

- Continued external training for IAB personnel without assessment of "goodness of fit" of the training with CASA, existing policy & process, and/or quality.

EXHIBIT A

298 Report

EXHIBIT A

Data Issues

- 298 report required provision of 3 separate databases, before report could be written
- Even then OIS data were "missing"
- Finally provided from "secret database"
- Noted issues to revise before 298 reports are valid

EXHIBIT A

298 Solutions

1. Remove obscure data.

2. Identify critical data points and report the data in the same manner each time.

3. Serial number all UoFs reported and develop a "lessons learned" document to drive future training.

4. Review 298 data for accuracy, completeness and timeliness (monthly).

EXHIBIT A

298 Solutions

5. Include a methodology section in each report component for each of the nine individual 298 components,

6. Clearly explain reporting processes used in compiling 298 data

7. Issue data-centric reports quarterly, including measurable goals and objectives and reporting progress towards such, to senior personnel

8. Track results over time. Ensure 298 data are not a sequence of “snapshots”

EXHIBIT A

298 Cont'd

9. Where there are discrepancies, ensure that data collection and analysis protocols and results are clear, accurate, and understandable

10. Implement an internal "Red Team" audit process to identify threats to data integrity before submission to Monitor.

298 cont'd

11. Ensure quarterly reports generated by the system are integrated with APD CASA activities

12. Subject every 298 report to "lessons learned" analysis and link to policy, training, supervision and remediation processes

13. Use that same information to improve 298 data reporting functions

EXHIBIT A

298 cont'd

14. Bolster the "data analytic" function of 298 instead of mere data dumping; Consider summative responses to data

EXHIBIT A